MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

June 26, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1541-P
Box 8012
Baltimore, Maryland 21244-8012

Re: file Code CMS-1541-P

Dear Ms Norwalk:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled *Medicare Program: Proposed Changes to the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008*, Federal Register Vol. 72, No. 86, pages 25356-25481 (May 4, 2007). We appreciate your staff's ongoing efforts to administer and improve the payment system for home health services, particularly considering the agency's competing demands.

In this letter, we comment on the categories the new resource groups, the variation within resource groups, payments for non-routine supplies, adjustment for changes in case-mix, and other miscellaneous issues.

General comments

The Commission appreciates that CMS has recognized the need for significant refinement of the home health prospective payment system (PPS). In prior reports we have discussed several issues that suggest the current system needs improvement, such as the dated case-mix weights and the variation in service use within the home health resource groups (HHRGs). These issues, in addition to the reduction in the average number of visits in a home health episode, suggest that the system may not reflect the current relationship between patient characteristics and episode costs for many patients.

CMS's intent with the proposed changes is to refine the accuracy of the home health PPS. The home health benefit has changed significantly since the advent of PPS, but the payment system's resource groups and relative weights are based on data from 1997 and 1998. This rule provides an important opportunity to revise the system based on more recent data about resource use.

New episode categories (the four equation model)

Under the new system a patient's clinical characteristics, functional limitations, therapy visits, and episode timing would determine payment. The rule would establish a new system of HHRGs that sort

episodes into 5 categories based on therapy use and an episode's timing in a sequence of consecutive episodes. The five category system provides higher payments for third and subsequent episodes in a sequence of consecutive episodes, and it would provide a graduated increase in payment for additional therapy visits.

The new system would retain the clinical, functional and service domains established in the current PPS, but would significantly restructure them. Under the current system there are 4 clinical, 5 functional, and 4 service groups, and the unique combinations of each of these groups comprise the current 80 home health resource groups. In the proposed system, there would be 3 clinical, 3 functional groups, and the number of service groups would vary based on the number of therapy visits in an episode. For patients with 13 or fewer therapy visits, there would be 5 service groups, and patients with 14-19 visits there are 3 severity groups. Patients with 20 or more therapy visits are included in one single group. The unique combinations of severity groups comprise the 153 resource groups in the proposed system.

The proposed changes include the establishment of separate clinical and functional severity scales for each category of HHRGs, and it also expands the number of clinical conditions that affect a patient's case-mix. For example, the new system will assign a cancer patient who is in a first or a second episode and uses little therapy to the lowest clinical severity category, while in later episodes a patient with that diagnosis would be assigned to a higher clinical severity category. As CMS notes, the separate severity scales reflect the finding that the relationship between clinical and functional characteristics and resource use varies among the categories. The addition of more clinical conditions to the case-mix allow for the effects of some secondary diagnosis and interactions between clinical conditions in the determination of the case-mix. The modifications should permit a more accurate measurement of patient resource use.

However, MedPAC is concerned about any payment system that ties payments explicitly to the level of services provided. Under the proposed payment system HHAs could potentially seek higher payments by providing more therapy or providing later episodes of home care. MedPAC will be analyzing the impact of changes in payments and utilization.

Payment accuracy in the new system

MedPAC analyzed the accuracy of the home health payment systems two ways: by examining the ratio of payments to cost, and by examining the variation in the amount of services used by patients in the same HHRG. Payment to cost ratios that are close or equal 1.0 are ideal, as they indicate that payments for an episode are near costs. However, we note that payment to cost ratios for home health are much higher because, as MedPAC has noted in several reports, home health payments substantially exceed costs. For this analysis, we will compare the range from the highest to the lowest payment to cost ratios across HHRGs.

Reviewing variation in the service use among the episodes within an HHRG allows us to determine if episodes are appropriately grouped. The episodes assigned to an HHRG should have similar levels of resource use, in the case of home health they should be similar in the number of visits provided. In prior reports, the Commission has noted that there is broad variation in service use within the HHRGs. The Commission has expressed concern that the within group variation suggests the payment system is inappropriately grouping dissimilar episodes in the same resource group, and creates the potential for agencies to favor profitable patients within a group. For this analysis, we will be comparing the coefficient of variation for the number of visits per episode, a measure of how episodes in an HHRG differ from the average episode. A lower coefficient is indicative that the episodes within an HHRG are internally homogenous, or are relatively similar in the number of visits provided.

Our payment to cost analysis found that the proposed changes would result in a more even distribution of payments relative to costs. We compared the payments for episodes with similar therapy visits and episode timing. MedPAC computed the average payments under the current and proposed payment systems for each group of episodes, and computed the payment to cost under the current HHRG-80 and the proposed HHRG-153 system. Under the current system, the payment to cost ratios for episodes with similar service use range from 1.02 to 1.73. Under the new system, the range between the ratios is narrowed, and range from 1.14 to 1.40. More uniform ratios reduce the differences in financial returns among different type of patients, and reduce the provider's preference for some patients. However, we note that margins will increase with the number of therapy visits. For example, patients that need 0-5 visits will average a margin of 12 percent, while those who need 20 or more visits will average 29 percent.

The coefficient of variation analysis found that the new system establishes a more internally homogenous set of HHRGs. The new system has more resource groups and uses two dimensions of service use, the number of visits provided and episode sequence, to classify episodes. Consequently, it has less within-group variation in the number of visits provided. The average coefficient of variation for visits has fallen from .81 in the current system to .75 for the proposed system of HHRGs. The reduction in variation means that the new resource groups are better at identifying episodes with similar resource use than the current system. The reduction in within-group variation reduces the potential for providers to select the least costly patients in a resource group.

This analysis suggests that the proposed changes will make a modest improvement in the accuracy of the system. However, the magnitude of the improvements will not obviate the need to continue to refine the payment system. MedPAC will explore other alternatives to improving the accuracy of the HHRGs, and urges CMS to continue efforts to refine the PPS.

Replacement of the therapy threshold

MedPAC has expressed concerns about the current threshold, which increases payments for episodes that have 10 or more therapy visits. The increase can be as much as $2,700 per episode. As MedPAC has noted in the past, and the analysis included in the rule suggests, having a single threshold that provides a significant incentive for providers to deliver just enough visits to meet the threshold. The proposed adjustment will make gradual payment increases with more therapy visits. The new system split the range of therapy visits from 0-20 visits into 9 thresholds, and provides smaller increases $273 to $646 dollars among the thresholds. The proposed changes also set lower payments for episodes that are very profitable under the current system, those in the 10-13 visit range, and raise payments for episodes that are not as profitable under the current system. The redistribution from episodes with the highest margins to less profitable episodes permits more appropriate payments for a broader range of episodes.

The experience with the current therapy threshold suggests that providers are sensitive to the financial incentives associated with therapy visits. It is difficult to anticipate how utilization may change under the new system. Agencies could respond by lowering or raising the number of visits provided, and it is unclear that guidelines exist to determine if these changes represent an improvement in care or an effort to maximize payment. Because of this uncertainty, and the likelihood that the change will vary among providers, analysis of the changes in therapy under the new system should be a key priority for future research. MedPAC will be assessing the changes in therapy patterns and home health outcomes that result from this rule, to follow how any changes in therapy volume affect beneficiaries and program spending.

Increased payments for 3rd and subsequent episodes

Medicare bundles payments for home health into 60 day episodes; beneficiaries can have multiply episodes if needed. CMS's found that the service use of third and subsequent episodes are greater than the average of first and second episodes. Based on this finding, CMS proposes to make higher payments for third and subsequent episodes. Similar to CMS's finding, MedPAC found that the average number of visits was greater in later stays. This variation indicates that the change proposed by CMS is reasonable.

MedPAC notes that the proposed rule is a refinement of the PPS, and is not changing home health coverage policy. The higher payments for later episodes reflect the higher service use compared to earlier episodes. The nature of third and subsequent stays deserves further research. MedPAC plans to assess the service these patients receive, to better understand how they differ from short-stay patients and if alternative forms of payment are warranted.

Non-routine supplies

CMS's analysis of the cost of non-routine supplies (NRS) found that they varied substantially among episodes, and suggested that a more targeted payment method is need for NRS. Currently, the system provides a uniform payment of $54 per episode, regardless of patient severity. Since NRS use varies widely, this overpays some agencies. For example, in 2003 MedPAC estimates that more than half of all episodes had costs below the amount included in the base payment in 2003, while the top quarter exceeded double the amount provided.

To explore alternatives to the current system, CMS developed a statistical model that measured the relationship between clinical characteristics and NRS cost. In its model CMS relied on the limited information about NRS charges and costs on the home health cost report. Cost to charge ratios were computed for each agency, and the NRS charges on each agency's claim were used to estimate episode-level NRS costs. Based on the results from this model, CMS developed a severity scale for NRS. Episodes would be assigned to one of five severity levels based on the clinical conditions of a beneficiary, and payments would be adjusted by a case-mix score that represents the mean NRS costs for each severity group. The explanatory power of the model was low, with an r-square of 13 percent.

This approach yields a small improvement in the targeting of payments for NRS. The analysis presented by CMS demonstrates that the current method pays too much for most episodes, and too little for episodes with moderate to high NRS use. The proposed change will better target NRS payments, but we also note that the low explanatory power of the NRS model indicates that CMS should continue efforts to refine the model.

The rule does not propose an outlier policy for NRS. CMS cites the lack of an administrative infrastructure for recording NRS cost and use, and also indicates that current reporting may not capture all NRS use. The low power of the NRS model suggests that including NRS in the home health outlier policy would help improve payment accuracy. NRS, like visits, are a covered service reimbursed through the home health PPS. The system already pays for outlier costs related to home health visits, and we see no reason to exclude NRS from this policy.

Wage index

MedPAC is proposing a new approach to the hospital wage index in our June 2007 report, as mandated by Congress in the Tax Relief and Health Care Act of 2006. MedPAC also recommends that CMS adopt our proposed method for home health agencies. Under this system home health agencies and hospitals in the same market would have the same wage index. The new methodology would utilize data that is

available for all labor areas, eliminating the need for imputing an index for agencies in areas with no hospital wage index. We urge CMS to begin implementing the new wage index recommended by the Commission for home health in the 2009 payment year.

Adjustment for changes in case mix

CMS has proposed an adjustment for case-mix changes related to changes in coding practices of 8.25 percent. The reduction is based on a review of changes in case-mix and patient characteristics between 2000 and 2003. CMS's review found that, adjusted for changes in the types of agencies participating in Medicare, case-mix increased from 1.13 to 1.23, a growth of 8.7 percent. CMS compares this with information about patient severity from the OASIS assessments, the reduction in the average visits per episode, other changes in the characteristics of home health patients and trends in resource cost. It concludes that this other data does not suggest a real increase in patient severity. Based on this, the rule posits that the 8.7 percent increase in case-mix is not related to severity. CMS proposes to recover the increase through an annual reduction of 2.75 percent to the payments in 2008-2010.

MedPAC did not independently assess the case-mix and patient data included in CMS's analysis, the findings are consistent with the prior experience with other prospective payment systems. Case-mix increases attributable to coding improvements are common when new payment systems are implemented. For example, an adjustment occurred at the inception of the inpatient hospital PPS. A second adjustment had to be made when the first proved inadequate. Other post-acute PPSs, such as the inpatient rehabilitation facility and long-term acute care hospital PPSs, have also been adjusted for case-mix increases. An adjustment for home health is consistent with the experience in other systems.

The review of patient severity and resource use presented by CMS suggests that coding improvements have occurred in the home health PPS. The analysis makes the best use of currently available data, but for the future it would be beneficial to have a more systematic approach to measuring changes to in coding practices. For example, CMS should consider efforts such as the collection of OASIS from independent entities for comparison to agency assessments or on-site visits to check agency coding practices. Better data would allow CMS to continually assess impact of coding adjustments, and enable to act swiftly when it occurs in the future.

The need for better data is particularly acute because this rule will present another opportunity for case-mix increases due to coding improvement, so there should be a prospective adjustment as well. The new rule expands the diagnosis codes and functional limitations that affect payment, and CMS should be wary of unwarranted increases in case-mix. CMS should consider a combined (retrospective and prospective) adjustment for this rule that would be taken over a longer period of time. In addition, CMS should continue to evaluate coding changes in future years to determine if additional coding improvement is occurring. If so, the agency should move promptly to reflect this additional change in home health payments.

Measurement of home health service use

The rule follows the methodology established at the implementation of the home health PPS to measure the resource costs of episodes and update the case-mix index (CMI). This method uses visit length and BLS wage data to compute the labor cost of a visit.

This is the first time CMS has updated the CMI since the inception of the PPS. Considering the rapid pace of change that can occur in health care delivery, CMS should consider updating the CMI with greater frequency to ensure payments accurately reflect the relative resource use of the different kinds of patients.

CMS should consider using the information on the cost report for measuring resource use. CMS currently uses salary information to estimate the costs of a visit, and does not include overhead costs. This method assumes indirect costs are proportional to direct costs, and it is not clear that this assumption is correct. MedPAC plans to examine the cost report data to see if provides better data on overhead costs. We suggest that CMS should assess its utility.

This information could be combined with claims information about home health charges to better assess labor costs. The current methodology assumes labor costs are constant across the continuum of patient severity. The charges recorded on a home health claim have the potential to reveal more information about the variation in labor costs across episode types. This information, combined with the cost report information on costs and charges, could be used to compute the per-visit discipline costs for different types of episodes. MedPAC plans to explore the use of this data for this purpose, and again we suggest CMS should assess the feasibility of using this data as well.

Information from the Medicare home health cost report is critical to these efforts. We encourage CMS and the home health industry to make every effort to ensure these reports are complete and accurate.

Revisions to the market basket

The rule proposes to update the market basket with new weights and prices proxies based on more recent data about the cost and prices of inputs. Using more recent data should ensure that the market basket reflects the input price changes faced by home health agencies.

New quality measures

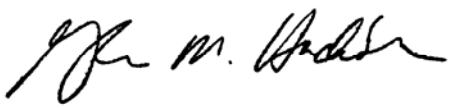
The rule proposes to add two new home health quality measures for wound care. The new measures would track the status for the healing of a wound, and would measure emergency room visits that result from wound infections. MedPAC commends CMS for adding these measures, which we note are consistent with our comments for the 2006 home health payment rule. In these comments, we also suggested that CMS develop measures for fall prevention. We understand that CMS has an effort underway in this area, and we look forward to reviewing this effort.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman